

Twelve Sacramento physicians have been president of the California Medical Association, and one of them, Dr. Thomas Logan, was president of the American Medical Association. He was the first California physician to be so honored. Dr. Logan was perhaps the greatest influence in the history of Sacramento medicine. One of the astonishing things about the early leaders of medicine in Sacramento was the incredible number of organizations to which they actively contributed and the remarkable number of scientific articles they were able to write. Horse and buggy days, indeed!

But Sacramento has its modern counterparts, which the future will more properly place in perspective. One of the exciting developments in this region is the new medical school on the Davis campus of the University of California, guided by an enthusiastic dean and staff. The rapid growth of medical facilities in Sacramento has come about without the loss of what is perhaps the most significant feature of our Society: The members look upon one another as friends and colleagues rather than as competitors. A fine *esprit de corps* prevails, which will enhance the numerous conferences and symposiums planned in celebration of the anniversary.

In recognition of the centennial celebration Dr. Dwight L. Wilbur, former editor, and Dr. Malcolm S. M. Watts, present editor, and the Editorial Board of CALIFORNIA MEDICINE have graciously permitted members of the Sacramento Society for Medical Improvement to contribute the scientific articles for this, the March issue. The Society and the authors are grateful for the opportunity to publish these papers which represent some of the present medical thought in the Sacramento Valley.

EDMUND E. SIMPSON, M.D.
Sacramento

Chemical Examination

IN RESPONSE TO the constantly growing demand for both old and new laboratory tests, physicians and industry have designed instruments for automated or semi-automated performance of laboratory tests which promise to provide larger numbers

of tests at lower costs. Some physicians have hailed this development and advocated "complete laboratory examination" to accompany the complete physical. Others have warned against abrogating clinical judgment in favor of multichannel test packages and have pleaded for more critical care in ordering tests. Whatever the merits of the opposing arguments, the geometric progression of tests ordered continues with a doubling time of four to five years as it has for the past 20 years. The trend now has all the earmarks of the "inevitability of progress." Perhaps the time has come to examine the practical uses of the proliferation of automated laboratory services rather than argue their merits.

The paper by Glassy and Blumenfeld elsewhere in this issue appears as a first and welcome step in that direction. As they imply, the outstanding advantage of automation is the ease of repetitive performance. In itself, this may lead merely to making the same mistake over and over again. In technical terms, precision does not imply accuracy. More bluntly, the result is not necessarily right, even if it is endlessly reproducible by the tireless machine.

In another context, the ease of repetitive examination offers the opportunity of defining not only normal values for a population but also the much narrower range within which individuals maintain their biochemical and hematologic parameters. Can we then hope to predict disease when an individual moves beyond his own range of normal, perhaps even if he remains within the boundaries of the normal values for the whole population? An example can be given. With a certain method the normal range of serum uric acid values for males between 40 and 60 years of age may be taken as 4 to 8 mg per 100 ml. Let it be assumed that there are two individuals whose uric acid levels had strayed between 4 and 4.5 mg per 100 ml and between 7.5 and 8.0 mg per 100 ml, respectively, for many years. Is the new appearance of a uric acid value of 6.5 mg per 100 ml as ominous in the first individual as 10.5 mg per 100 ml in the second? It appears imperative that these questions be answered before large scale repetitive laboratory examinations are begun in the name of preventive medicine. Even if it turns out that variations by the individual from his own norm improves the predictive value of laboratory examinations, repetitive tests may still not be useful unless the prediction can be translated into preventive action. Prognosis, however, has almost always preceded development of therapy. We may hope that better un-

derstanding of the natural history of diseases, provided in part by such studies as now undertaken by Glassy and Blumenfeld, will eventually lead to improvement of our therapeutic as well as our prognostic armamentarium.

A Commission on Medical Economics

DURING A CENTURY of increasing evidence of man's terrifying destructive capabilities, the medical profession has steadfastly labored for the improvement of mankind.

In the understanding of disease processes, in the cure and amelioration of disease and in the search for hitherto unidentified disease, the progress of the past century surpasses all of the advances of preceding years.

While it would seem quite proper at a centennial celebration to list in great detail the glories of the past, what is to be gained thereby? The benefits of previous discoveries are already here. Better, at this time of celebration, that we take upon ourselves the responsibility of seeking out those areas wherein our predecessors, great as they were, did not fulfill their own aspirations.

Specifically we can concern ourselves with the financing and distribution of medical care. A mature and responsible medical society should recognize the existence of the gap between available medical knowledge and the delivering of it to those who need it. Unfortunately, the medical genius of the past has been so engrossed in the scientific aspect of disease that it had little time to concern itself with the mundane problems of distribution of medical care. The simple market transaction involved in getting medical care to the patient was somehow or other not a primary medical concern.

It is now abundantly clear that the public will tolerate nothing short of adequate medical care available to the entire body politic. The only problem at issue is whether this care is to be provided in conformity with our current economic structure or through a system of taxation. The medical profession can no longer struggle from expediency to expediency while others seek out and

identify deficiencies in the distribution of medical care. The clock is running out. Each year brings an additional program of tax-supported medicine. Neither of the major political parties can possibly turn the clock back. If there is to be a desirable solution to the problem of financing and distributing medical care, a great part of the solution must come from the medical profession itself. Either we assume the leadership in sponsoring and developing programs within the economic reach of every person or we forfeit to government.

Organized medicine alone is obviously in no position to solve the social and economic problems associated with the marketing of medical care. The multiplicity of disciplines providing care and the varied mechanisms in vogue for financing it make a unilateral approach inadequate. A durable solution can be expected only if all the providers, underwriters and recipients of service are represented and involved in the planning process. It is necessary that the medical profession, representatives of the insurance industry, hospital associations, allied disciplines, government, educational institutions and consumer groups join in a combined endeavor.

Today our future depends on strength of leadership. Financial means are available, medical knowledge is abundant. Only the techniques of the market transaction are lacking. Does it not seem prudent, therefore, to form a commission on the economics and distribution of medical care and to charge that commission with the responsibility of studying the problems entailed in bringing all the involved parties into comfortable partnership. It is expected that a joint effort, led by the medical profession would challenge all the participants: Government representatives, insurance executives, consumer representatives, physicians and allied health personnel — all would be placed in a position of responsibility for the outcome.

The popularity of federalized medicine is based almost exclusively on the economic problems associated with illness. It is extremely doubtful that, given reasonable alternatives, the public would trade private care for government care. It is quite obvious today that our generation faces the challenge of finding the alternatives. A commission on medical economics seems a most logical beginning.

A. E. BERMAN, M.D.
Sacramento